

§ 414.48

42 CFR Ch. IV (10–1–09 Edition)

(1) To bill the base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units.

(2) If the physician is not present with the resident during pre- and post-anesthesia care, then the physician may bill the case as a medically directed case in accordance with paragraph (d) of this section.

(f) *Physician medically supervises anesthesia services.* If the physician medically supervises more than four concurrent anesthesia services, CMS bases the fee schedule amount on an anesthesia-specific CF and three base units. This represents payment for the physician's involvement in the pre-surgical anesthesia services.

(g) *Payment for medical or surgical services furnished by a physician while furnishing anesthesia services.* (1) CMS allows separate payment under the fee schedule for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. CMS makes payment for these services in accordance with the general physician fee schedule rules in § 414.20. These services are described in program operating instructions.

(2) CMS makes no separate payment for other medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

(h) *Physician involved in multiple anesthesia services.* If the physician is involved in multiple anesthesia services for the same patient during the same operative session, the carrier makes payment according to the base unit associated with the anesthesia service having the highest base unit value and anesthesia time that encompasses the multiple services. The carrier makes payment for add-on anesthesia codes according to program operating instructions.

[56 FR 59624, Nov. 25, 1991, as amended at 57 FR 42492, Sept. 15, 1992; 58 FR 63687, Dec. 2, 1993; 60 FR 63177, Dec. 8, 1995; 64 FR 59441, Nov. 2, 1999; 67 FR 80041, Dec. 31, 2002; 68 FR 63261, Nov. 7, 2003]

§ 414.48 Limits on actual charges of nonparticipating suppliers.

(a) *General rule.* A supplier, as defined in § 400.202 of this chapter, who is nonparticipating and does not accept assignment may charge a beneficiary an amount up to the limiting charge described in paragraph (b) of this section.

(b) *Specific limits.* For items or services paid under the physician fee schedule, the limiting charge is 115 percent of the fee schedule amount for nonparticipating suppliers. For items or services CMS excludes from payment under the physician fee schedule (in accordance with section 1848 (j)(3) of the Act), the limiting charge is 115 percent of 95 percent of the payment basis applicable to participating suppliers as calculated in § 414.20(b).

[58 FR 63687, Dec. 2, 1993, as amended at 62 FR 59102, Oct. 31, 1997]

§ 414.50 Physician or other supplier billing for diagnostic tests performed or interpreted by a physician who does not share a practice with the billing physician or other supplier.

(a) *General rules.* (1) For services covered under section 1861(s)(3) of the Act and paid for under part 414 of this chapter (other than clinical diagnostic laboratory tests paid under section 1833(a)(2)(D) of the Act, which are subject to the special billing rules set forth in section 1833(h)(5)(A) of the Act), if a physician or other supplier bills for the technical component (TC) or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to such physician or other supplier through common ownership or control as described in § 413.17 of this chapter) and the diagnostic test is performed by a physician who does not share a practice with the billing physician or other supplier, the payment to the billing physician or other supplier (less the applicable deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(i) The performing supplier's net charge to the billing physician or other